Minnesota Department of Health
Compliance Monitoring Division
Managed Care Systems Section

Final Report
For
PreferredOne Community Health Plan

Quality Assurance Examination
For the period:
August 1, 2006 through December 31, 2008

Final Issue Date:
July 10, 2009

Examiners:
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Minnesota Department of Health
Executive Summary:

The Minnesota Department of Health (MDH) conducted a Quality Assurance Examination of PreferredOne Community Health Plan (PCHP) to determine whether it is operating in accordance with Minnesota law. MDH has found that PCHP is compliant with Minnesota and Federal law, except in the areas outlined in the "Deficiencies" and "Mandatory Improvements" sections of this report. "Mandatory Improvements" are required corrections that must be made to policy/procedures, documents or processes to be compliant with the law but have not yet adversely affected enrollees or enrollee rights. The "Recommendations" listed are areas where, although compliant with law, MDH identified improvement opportunities.

To address recommendations, PCHP should:
Expand its policy/procedure to include specifics as to its process for same or similar specialty review.

To address mandatory improvements, PCHP and its delegates must:
Develop and implement consistent written appointment scheduling guidelines for urgent care and the definitions of "urgently needed care" and "emergency care" in policies and it must be consistent with the definitions as stated in Minnesota Rule 4685.0100, subparts 5 and 16.

Include in the continuity of care policy or written plan the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances require them to have a longer transition period or be transferred to nonparticipating providers; who will identify these enrollees and what criteria will be used for this determination; and how continuity of care will be provided for the identified enrollees.

Revise its policy, COC and practice such that when an initial determination is made not to certify, notification is provided by telephone within one working day after making the determination to the attending health care professional and a written notification is sent to the attending health care professional and enrollee and the language and definitions are consistent with the statute.

Provide specific documentation in the files as to which provider was verbally notified when an initial determination is made not to certify.

Clarify the language in its policy regarding the total number of additional days given for an extension due to lack of information.

Include in its appeal extension policy that the HMO may take up to 14 additional days to notify the enrollee and attending health care professional of its determination and that it must inform the enrollee and attending health care professional in advance of the extension and the reasons for the extension.

Include information about the reviewer from the initial determination in all of its appeal files for review in order to determine that the appeal review was conducted by a physician who did not make the initial determination not to certify.

To address deficiencies, PCHP and its delegates must:
Develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities according to Minnesota law.

Provide the proper notifications that include appeal rights when denying services.

Include in its appeal notification the right to submit the appeal to the external review process and the procedure for initiating if the initial determination is not reversed.

Include in its notification letters the right to file a complaint directly to the Commissioner of Health regarding a determination not to certify.

This report including these recommendations, mandatory improvements and deficiencies is approved and adopted by the Minnesota Commissioner of Health pursuant to authority in Minnesota Statutes, chapter 62D.

______________________________________	_________________________
Darcy Miner, Director Compliance Monitoring Division	Date

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I. Introduction

A. History:

PreferredOne Community Health Plan ("PCHP") is a Minnesota nonprofit corporation incorporated on December 2, 1994 under Chapter 317A of the Minnesota statutes. PCHP became operational in 1996. Contributing members of PCHP are Fairview Health Services and North Memorial Health Care. A non-contributing member is PreferredOne Physician Associates. Minnesota statutes provide that 40% of an HMO's board be enrollees of the plan. The current Board of Directors consists of ten members: two representatives each from Fairview, North Memorial, and PPA. Four consumer board members are elected by the PCHP membership.

PCHP offers a variety of fully insured health care plans for both large and small employers and features an open-access provider network, where members may receive care from any primary care physician or specialist in the network without a referral. The network features more than 12,700 physicians – 6,300 primary care and 6,400 specialists – and 240 plus hospitals.

B. Membership: PCHP self-reported enrollment as of December 31, 2008 consisted of the following:

Product	Enrollment
Co-pay Plans	6619
Deductible Plans	27544
HSA Qualified High Deductible Plans	14052
PCA Tiered Network Products	339
Conversion Plans	166
Small Employer Groups included in all of above	
Total	**48,720**

C. Onsite Examination Dates: April 13, 2009 through April 16, 2009

D. Examination Period: August 1, 2006 through December 31, 2008
File Sample Period: January 1, 2008 through December 31, 2008

E. National Committee for Quality Assurance (NCQA): PCHP is accredited by NCQA based on 2006 standards. The Minnesota Department of Health (MDH) evaluated and used results of the NCQA review in one of three ways.

a. If NCQA standards do not exist or are not as stringent as Minnesota law, the review results will not be used for evaluation [no NCQA box].
b. If the NCQA review was the same or more stringent than Minnesota law and the health plan was accredited with 100% of the possible points, the NCQA review result was accepted as meeting Minnesota requirements [☒NCQA] unless evidence existed indicating further investigation was warranted [☐NCQA].
c. If the NCQA standard was the same or more stringent than Minnesota law, but the review resulted in less than 100% of the possible points on NCQA's score sheet or as an identified opportunity for improvement, MDH conducted its own examination.

F. Sampling Methodology: Due to the small sample sizes and the methodology used for sample selection for the quality assurance examination, the results cannot be extrapolated as an overall deficiency rate for the health plan.

G. Performance Standard: For each instance of non-compliance with applicable law or rule identified during the course of the quality assurance examination, which covers a three-year audit period, the health plan is cited with a deficiency.

II. Quality Program Administration

Minnesota Rules, Part 4685.1110. Program

Subp. 1.	Written Quality Assurance Plan	☒Met	☐Not Met	☐NCQA
Subp. 2.	Documentation of Responsibility	☐Met	☐Not Met	☒NCQA
Subp. 3.	Appointed Entity	☐Met	☐Not Met	☒NCQA
Subp. 4.	Physician Participation	☐Met	☐Not Met	☒NCQA
Subp. 5.	Staff Resources	☐Met	☐Not Met	☒NCQA
Subp. 6.	Delegated Activities	☐Met	☒Not Met	☐NCQA[1]
Subp. 7.	Information System	☐Met	☐Not Met	☒NCQA
Subp. 8.	Program Evaluation	☐Met	☐Not Met	☒NCQA
Subp. 9.	Complaints	☒Met	☐Not Met	
Subp. 10.	Utilization Review	☒Met	☐Not Met	
Subp. 11.	Provider Selection and Credentialing	☒Met	☐Not Met	☒NCQA
Subp. 12.	Qualifications	☐Met	☐Not Met	☒NCQA
Subp. 13.	Medical Records	☐Met	☐Not Met	☒NCQA

Subp. 6. Minnesota Rules, part 4685.1110, subpart 6, states the HMO must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities. The standards established by the National Committee for Quality Assurance (NCQA) for delegation are considered the community standard and, as such, were used for the purposes of this examination. The following delegated entities and functions were reviewed:

Delegated Entities and Functions								
	UM	**UM Appeals**	**QM**	**Complaints**	**Cred**	**Claims**	**Network**	**Disease Mgmt**
Express Scripts, Inc. (PBM)						x	x	
Behavioral Healthcare Providers (BHP)	x	x	x	x QOC	x		x	
Health Services Mgmt (HSM) (Chiropractic)	x	x	x	x QOC	x		x	
Accordant								x
LifeMasters								x

[1] NCQA delegation standards are equivalent to Minnesota law for credentialing and quality improvement functions only.

Review of PCHP's oversight file audits of HSM and BHP revealed that PCHP audited the delegates' performance for utilization management (denial and appeal files) for NCQA elements and most of the utilization management requirements in Minnesota law. However, PCHP failed to review several of the Minnesota requirements as set forth in deficiencies two, three, and four. This is a repeat finding. **(Deficiency #1)**

Minnesota Rules, Part 4685.1115. Activities

Subp.	Requirement	Met	Not Met	NCQA
Subp. 1.	Ongoing Quality Evaluation	☐	☐	☒
Subp. 2.	Scope	☐	☐	☒

Minnesota Rules, Part 4685.1120. Quality Evaluation Steps

Subp.	Requirement	Met	Not Met	NCQA
Subp. 1.	Problem Identification	☐	☐	☒
Subp. 2.	Problem Selection	☐	☐	☒
Subp. 3.	Corrective Action	☐	☐	☒
Subp. 4.	Evaluation of Corrective Action	☐	☐	☒

Minnesota Rules, Part 4685.1125. Focused Study Steps

Subp.	Requirement	Met	Not Met
Subp. 1.	Focused Studies	☒	☐
Subp. 2.	Topic Identification and Selection	☒	☐
Subp. 3.	Study	☒	☐
Subp. 4.	Corrective Action	☒	☐
Subp. 5.	Other Studies	☒	☐

Minnesota Rules, Part 4685.1130. Filed Written Plan and Work Plan

Subp.	Requirement	Met	Not Met	NCQA
Subp. 1.	Written Plan	☒	☐	
Subp. 2.	Work Plan	☐	☐	☒

III. Complaints Systems

Complaint System

MDH examined PCHP's fully-insured commercial complaint system under Minnesota Statutes, chapter 62Q. MDH reviewed a total of 58 complaints system files:

Complaint System Files	
Complaint System File Source	**# Reviewed**
Complaint Files	34
Non-clinical Appeal Files	13
Quality of Care Files	11
Total	**58**

Minnesota Statutes, Section 62Q.69. Complaint Resolution

Subd. 1.	Establishment	☒Met ☐Not Met
Subd. 2.	Procedures for filing a complaint	☒Met ☐Not Met
Subd. 3.	Notification of Complaint Decisions	☒Met ☐Not Met

Minnesota Statutes, Section 62Q.70. Appeal of the Complaint Decision

Subd. 1.	Establishment	☒Met ☐Not Met
Subd. 2.	Procedures for Filing an Appeal	☒Met ☐Not Met
Subd. 3.	Notification of Appeal Decisions	☒Met ☐Not Met

Subd. 3(b). Minnesota Statutes, section 62Q.70, subdivision 3(b), states, if the appeal decision is partially or wholly adverse to the complainant, the notice must advise of the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process. MDH noted in one appeal file, the original determination was partially overturned, leaving the enrollee some uncovered charges. However, the response letter did not include the right to external review.

Minnesota Statutes, Section 62Q.71. Notice to Enrollees

☒Met ☐Not Met

Minnesota Rules, Part 4685.1900. Records of Complaints

Subp. 1.	Record Requirements	☒Met ☐Not Met
Subp. 2.	Log of Complaints	☒Met ☐Not Met

Minnesota Statutes, Section 62Q.73. External Review of Adverse Determinations

Subd. 3.	Right to external review	☒Met ☐Not Met

IV. Access and Availability

Minnesota Statutes, Section 62D.124. Geographic Accessibility

Subd. 1.	Primary Care; Mental Health Services; General Hospital Services	☒Met ☐Not Met
Subd. 2.	Other Health Services	☒Met ☐Not Met
Subd. 3.	Exception	☒Met ☐Not Met

Minnesota Rules, Part 4685.1010. Availability and Accessibility

Subp. 2.	Basic Services	☒Met ☐Not Met
Subp. 5.	Coordination of Care	☒Met ☐Not Met
Subp. 6.	Timely Access to Health Care Services	☐Met ☒Not Met

Subp. 6. Minnesota Rules, 4685.1010, subpart 6, states that the HMO must develop and implement written appointment scheduling guidelines based on type of health care service. The guidelines must be consistent with the definitions of "emergency care" as outlined in Minnesota Rules 4685.0100, subpart 5 and "urgently needed care" as defined in Minnesota Rules, subpart 16. Policies entitled *Availability of Practitioners and Guidelines for Practitioner Expansion (NM019)* and *Standards of Appointment Access (NM032)* have conflicting access standards for urgent care. The access standard for urgent care must be 24 hours. The Provider Manual also states the access standard for urgent care is 48 rather than 24 hours. In addition, the definition of "urgent care" in policy *Timelines of Behavioral Health, Non-Behavioral Health, Chiropractic and Pharmacy Decisions (MM/P005)* is incorrect and inconsistent with definitions of urgent care in other policies. The timelines and definitions for urgent and emergent care must be consistent between policies and be compliant with the definitions as stated in Minnesota Rules.
(Mandatory Improvement #1)

Minnesota Statutes, Section 62Q.55. Emergency Services

☒Met ☐Not Met

Minnesota Statutes, Section 62Q.121. Licensure of Medical Directors

☒Met ☐Not Met

Minnesota Statutes, Section 62Q.527. Coverage of Nonformulary Drugs for Mental Illness and Emotional Disturbance

Subd. 2.	Required Coverage for Anti-psychotic Drugs	☒Met ☐Not Met
Subd. 3.	Continuing Care	☒Met ☐Not Met
Subd. 4.	Exception to formulary	☒Met ☐Not Met

Minnesota Statutes, Section 62Q.535. Coverage for Court-Ordered Mental Health Services

Subd. 1.	Mental health services	☒Met ☐Not Met
Subd. 2.	Coverage required	☒Met ☐Not Met

Minnesota Statutes, Section 62Q.56. Continuity of Care

Subd. 1.	Change in health care provider; general notification	☐Met ☒Not Met
Subd. 1a.	Change in health care provider; termination not for cause	☒Met ☐Not Met
Subd. 1b.	Change in health care provider; termination for cause	☒Met ☐Not Met
Subd. 2.	Change in health plans	☒Met ☐Not Met
Subd. 2a.	Limitations	☒Met ☐Not Met
Subd. 2b.	Request for authorization	☒Met ☐Not Met
Subd. 3.	Disclosures	☒Met ☐Not Met

Subd. 1. Minnesota Statutes, section 62Q.56, subdivision 1, states that the HMO will prepare a written plan that includes, in pertinent part, the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to nonparticipating providers; who will identify these enrollees and what criteria will be used for this determination; and how continuity of care will be provided for the identified enrollees. PCHP's policy entitled *Transition of Care for Continuity and Safety (MP/T002)* does not include these provisions. In interviews, staff indicated claims are pulled for the past year to identified enrollees affected by a contract termination. The enrollees are informed by letter. Enrollees with special needs or risks are not identified in that all members are treated the same. **(Mandatory Improvement #2)**

Minnesota Rules, 4685.0700. Comprehensive Health Maintenance Services

Subp. 3.	Permissible limitations	☒Met ☐Not Met
Subp. 4.	Permissible exclusions	☒Met ☐Not Met

V. Utilization Review

MDH examined PCHP's fully-insured commercial utilization review system under Minnesota Statutes, chapter 62M.

MDH reviewed a total of 90 Utilization Review System files as follows:

Utilization Review Files	
Utilization Review File Source	**# Reviewed**
PCHP UM Denials	31
HSM UM Denials	11
BHP UM Denials	2
PCHP UM Appeals	24
HSM UM Appeals	31
BHP UM Appeals	1
Total	**90**

Minnesota Statutes, Section 62M.04. Standards for Utilization Review Performance

Subd. 1. Responsibility on Obtaining Certification ☒Met ☐Not Met
Subd. 2. Information upon which Utilization Review is Conducted
☒Met ☐Not Met
Subd. 3. Data Elements ☒Met ☐Not Met
Subd. 4. Additional Information ☒Met ☐Not Met
Subd. 5. Sharing of Information ☒Met ☐Not Met

Minnesota Statutes, Section 62M.05. Procedures for Review Determination

Subd. 1. Written Procedures ☒Met ☐Not Met
Subd. 2. Concurrent Review ☐Met ☐Not Met ☒NCQA
Subd. 3. Notification of Determinations ☒Met ☐Not Met
Subd. 3a. Standard Review Determination
(a) Initial determination to certify (10 business days)
☒Met ☐Not Met ☐NCQA
(b) Initial determination to certify (telephone notification)
☒Met ☐Not Met
(c) Initial determination not to certify ☐Met ☒Not Met
(d) Initial determination not to certify (notice of rights to external appeal)
☐Met ☒Not Met ☐NCQA
Subd. 3b. Expedited Review Determination ☒Met ☐Not Met ☐NCQA
Subd. 4. Failure to Provide Necessary Information ☐Met ☒Not Met
Subd. 5. Notifications to Claims Administrator ☒Met ☐Not Met

Subd. 3a.(a). Minnesota Statutes, section 62M.05, subdivision 3a.(a), states that an initial determination must be communicated to the provider and enrollee within 10 business days (15 calendar days). MDH noted one file took longer than 15 calendar days (28 days).

Subd. 3a.(c). Minnesota Statutes, section 62M.05, subdivision 3a.(c), states that when an initial determination is made not to certify, notification must be provided by telephone within one working day after making the determination to the attending health care professional and hospital and a written notification must be sent to the hospital, attending health care professional, and enrollee. PCHP's language in the COC, which was approved by MDH, states the verbal notification goes to the "attending provider" rather than the "attending health care professional". At the time of approval of the COC language, MDH believed the term "attending provider" was

the same as “attending health care professional”. In most cases the attending provider and attending health care professionals are the same. However, in cases involving third party vendors such as DME, home health or therapies, this may not be the case. In 14 utilization files involving third party vendors, the verbal notification was made to the vendor of the service rather than the attending health care professional. In addition, two files did not contain a written notification to the attending health care professional and one of those did not contain a written notification to the enrollee. In the above files, PCHP was following the process outlined in its approved COC, however the attending health care professional did not receive verbal notification. Written notification was given to the attending health care professional in all but the two files noted. PreferredOne must change its policy, COC and practice such that the attending health care professional receives the verbal and written notification and must use language and definitions consistent with the statute. (**Mandatory Improvement #3**). Further, the documentation of the verbal notification in the file needs to be specific as to which provider was verbally notified. **(Mandatory Improvement #4)**

Subd. 3a.(c) and (d). Minnesota Statutes, section 62M.05, subdivision 3a.(c) and (d), include verbal and written notifications of the denial and the written notification must include appeal rights. BHP had only two UM denials in the file sample period of one year. PreferredOne stated that BHP reviewers do not deny services but work with the requesting provider to “negotiate” the authorization. Services requested but not approved are denials within the meaning of Minnesota Statutes, section 62M.05, subdivision 3a, (c) and (d), therefore must include proper verbal and written notification that includes appeal rights. This is a repeat finding. **(Deficiency #2)**

Subd. 4. Minnesota Statutes, section 62M.05, subdivision 4, states that the HMO must have written procedures to address the failure of a provider or enrollee to provide the necessary information for review. PCHP’s policy *Timeliness of Behavioral Health, non-behavioral health, Chiropractic, and Pharmacy Decisions (MM/P005)* was unclear as to the total number of days for the extension. The staff interviewed were unable to provide further clarity as to the total number of days given for an extension due to lack of information. PCHP must more clearly indicate its process and the total number of additional days given for the extension in its policy. **(Manadatory Improvement #5)** All files reviewed with an extension were well within 45 days.

Minnesota Statutes, Section 62M.06. Appeals of Determinations not to Certify

Subd. 1.	Procedures for Appeal	☒Met	☐Not Met	
Subd. 2.	Expedited Appeal	☒Met	☐Not Met	
Subd. 3.	Standard Appeal			
	(a) Appeal resolution notice timeline	☐Met	☒Not Met	
	(b) Documentation requirements	☒Met	☐Not Met	
	(c) Review by a different physician	☐Met	☒Not Met	☐NCQA
	(d) Time limit in which to appeal	☒Met	☐Not Met	
	(e) Unsuccessful appeal to reverse determination	☒Met	☐Not Met	☐NCQA
	(f) Same or similar specialty review	☒Met	☐Not Met	
	(g) Notice of rights to External Review	☐Met	☒Not Met	☐NCQA
Subd. 4.	Notifications to Claims Administrator	☒Met	☐Not Met	

Subd. 3.(a). Minnesota Statutes, section 62M.06, subdivision 3(a), states that if the utilization review organization cannot make a determination within 30 days due to circumstances outside

the control of the HMO, the HMO may take up to 14 additional days to notify the enrollee and attending health care professional of its determination and it must inform the enrollee and attending health care professional in advance of the extension and the reasons for the extension. PCHP's policy entitled *Pre-service Appeals Policy and Procedures (MM/P008A)* states that extending the time frame to obtain additional information will be allowed if the member voluntarily agrees. There were no appeal files reviewed that required an extension. PCHP must revise its policy to include the 14 day time frame, it must inform the enrollee and attending health care professional in advance, and include the reasons for the extension. **(Mandatory Improvement #6)**

Subd. 3.(c). Minnesota Statutes, section 62M.06, subdivision 3(c), states that prior to upholding the initial determination not to certify for clinical reasons, the review must be conducted by a physician who did not make the initial determination not to certify. MDH noted in one file, the appeal was upheld by the same physician who made the initial determination. In most of the HSM appeal files, not enough information was included in the file to determine if a different physician upheld the appeal. PCHP's delegates must include information about the initial determination reviewer in all of its appeal files for review in the examination. **(Mandatory Improvement #7)**

Subd. 3.(f). Minnesota Statutes, section 62M.06, subdivision 3(f), states that in cases of upholding the determination not to certify, the HMO must ensure that a physician in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion reviews the case. Policies submitted for review have no specifics as to what cases get sent for specialty review and the process for doing so. PCHP should expand its policy/procedure to include specifics as to its process for same or similar specialty review. **(Recommendation #1)**

Subd. 3.(g). Minnesota Statutes, section 62M.06, subdivision 3(g), states if the initial determination is not reversed on appeal, the HMO must include in its notification the right to submit the appeal to the external review process described and the procedure for initiating. In 10 HSM files, the appeal notification letter did not contain the right to submit the appeal to the external appeal process. **(Deficiency #3)**

Minnesota Statutes, Section 62M.08. Confidentiality

☐Met ☐Not Met ☒NCQA

Minnesota Statutes, Section 62M.09. Staff and Program Qualifications

Subd. 1.	Staff Criteria	☐Met	☐Not Met	☒NCQA
Subd. 2.	Licensure Requirement	☒Met	☐Not Met	☐NCQA
Subd. 3.	Physician Reviewer Involvement	☒Met	☐Not Met	☐NCQA
Subd. 3a.	Mental Health and Substance Abuse Review	☒Met	☐Not Met	
Subd. 4.	Dentist Plan Reviews*	☐Met	☐Not Met	☐NCQA
Subd. 4a.	Chiropractic Reviews	☒Met	☐Not Met	☐NCQA
Subd. 5.	Written Clinical Criteria	☒Met	☐Not Met	☐NCQA
Subd. 6.	Physician Consultants	☒Met	☐Not Met	☐NCQA

Subd. 7.	Training for Program Staff	☐Met ☐Not Met ☒NCQA
Subd. 8.	Quality Assessment Program	☐Met ☐Not Met ☒NCQA

*Subdivision 4 regarding Dental Plan Reviews is not applicable as PCHP does not have a dental benefit.

Minnesota Statutes, Section 62M.10. Accessibility and on-site Review Procedures

Subd. 1.	Toll-free Number	☐Met ☐Not Met ☒NCQA
Subd. 2.	Reviews during Normal Business Hours	☐Met ☐Not Met ☒NCQA
Subd. 7.	Availability of Criteria	☒Met ☐Not Met

Minnesota Statutes, Section 62M.11. Complaints to Commerce or Health

☐Met ☒Not Met

Minnesota Statutes, Section 62M.11, states that an enrollee may file a complaint directly to the commissioner responsible for regulating the utilization review organization regarding a determination not to certify. In all 11 of HSM UM denial files, the determination letter contained the right to file a complaint with the Department of Commerce rather than the Department of Health. **(Deficiency #4)**

Minnesota Statutes, Section 62M.12. Prohibition on Inappropriate Incentives

☐Met ☐Not Met ☒NCQA

Minnesota Statutes, Section 62D.12. Prohibited Practices

Subd. 19.	Coverage of service	☒Met ☐Not Met

VI. Recommendations

1. In order to better comply with Minnesota Statutes, section 62M.06, subdivision 3(f), PCHP should expand its policy/procedure to include specifics as to its process for same or similar specialty review.

VII. Mandatory Improvements

1. In order to comply with Minnesota Rules, 4685.1010, subpart 6, PCHP must develop and implement consistent written appointment scheduling guidelines for urgent care and the definitions of “urgently needed care” and “emergency care” in the policies must be consistent with the definitions as stated in Minnesota Rule 4685.0100, subparts 5 and 16.

2. In order to comply with Minnesota Statutes, section 62Q.56, subdivision 1, PCHP must include in the continuity of care policy or written plan the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances require them to have a longer transition period or be transferred to nonparticipating providers; who will identify these enrollees and what criteria will be used for this determination; and how continuity of care will be provided for the identified enrollees.

3. In order to comply with Minnesota Statutes, section 62M.05, subdivision 3a.(c), PCHP must revise its policy, COC and practice such that when an initial determination is made not to certify, notification is provided by telephone within one working day after making the determination to the attending health care professional and a written notification is sent to the attending health care professional and enrollee and the language and definitions must be consistent with the statute.

4. In order to comply with Minnesota Statutes, section 62M.05, subdivision 3a.(c), PCHP must provide specific documentation in the files as to which provider was verbally notified.

5. In order to comply with Minnesota Statutes, section 62M.05, subdivision 4, PCHP must clarify the language in its policy regarding the total number of additional days given for the extension.

6. In order to comply with Minnesota Statutes, section 62M.06, subdivision 3(a), PCHP must include in its appeal extension policy that the HMO may take up to 14 additional days to notify the enrollee and attending health care professional of its determination and that it must inform the enrollee and attending health care professional in advance of the extension and the reasons for the extension.

7. In order to comply with Minnesota Statutes, section 62M.06, subdivision 3(c), PCHP's delegates must include information about the reviewer from the initial determination in all of its appeal files for review in order to determine that the appeal review was conducted by a physician who did not make the initial determination not to certify.

VIII. Deficiencies

1. In order to comply with Minnesota Rules, part 4685.1110, subpart 6, PCHP must develop and implement review and reporting requirements to assure that the delegated entity performs all delegated activities according to Minnesota law.

2. In order to comply with Minnesota Statutes, section 62M.05, subdivision 3a (c) and(d), PCHP's delegate must, when denying services, provide the proper notifications that include appeal rights.

3. In order to comply with Minnesota Statutes, section 62M.06, subdivision 3(g), PCHP's delegated entity, HSM, must include in its appeal notification the right to submit the appeal to the external review process and the procedure for initiating if the initial determination is not reversed.

4. In order to comply with Minnesota Statutes, section 62M.11, PCHP's delegated entity, HSM, must include in its notification letters the right to file a complaint directly to the Commissioner of Health regarding a determination not to certify.